CHAPTER 8

OASIS IN DETAIL

A. INTRODUCTION

The OASIS data set has multiple purposes within a home health agency. Because of this, it is imperative to ensure that accurate, high quality data are collected. All clinical staff who collect OASIS data should be aware of five specific aspects of data collection: (1) the patients from whom data are collected, (2) the time points for data collection, (3) the conventions or "rules" to observe in collecting and recording data, (4) the meaning of each OASIS item, and (5) how OASIS data are collected in the context of the comprehensive assessment. The patients who are to receive the comprehensive assessment (and OASIS data collection) were discussed in Chapter 4 of this manual, and the time points also were identified in that chapter. This chapter will address the remaining three aspects of data collection.

B. CONVENTIONS (RULES) TO FOLLOW

Both clinical assessment and outcome measurement depend on the collection and analysis of accurate data. All clinical staff who collect OASIS data should be aware of the basic conventions or "rules" to observe in collecting and recording OASIS data.

- *All the items refer to the patient's USUAL STATUS or condition at the time period or visit under consideration — unless otherwise indicated.* Though patient status can vary from day to day and during a given day, the OASIS response should be selected that describes the patient's status most of the time during the specific day under consideration. While learning or becoming familiar with the OASIS, care providers should read through all scale levels of the activity or attribute being evaluated before selecting the level that best describes the patient's status or capability on the day of the assessment.

  The patient status that is recorded pertains to the day of the assessment unless otherwise indicated. A few OASIS items address events or circumstances that occurred within the 14-day period immediately preceding the assessment (e.g., M0175 - Inpatient Facility Discharge, M0200 - Medical or Treatment Regimen Change, M0510 - Urinary Tract Infection, etc.). These items specifically identify this time period in the wording of the question. Item M0830 - Emergent Care identifies a more open-ended time period of "since the last time OASIS data were collected," which might be up to 60 days. Other than these situations, which are noted in the specific item

instructions, all other items address the patient's status, circumstance, or condition on the day of the assessment.

- *OASIS items should be completed accurately and comprehensively, and skip patterns should be used correctly.* Clinicians should monitor the accuracy and completeness of their own responses as they utilize the data set. Supervisory or clerical staff also may perform visual review to monitor correct observance of the skip logic, particularly when the clinician is being oriented and trained in OASIS data collection. Completeness of the OASIS information is critical for care planning as well as case mix reporting and performance improvement based on outcomes.

  As noted, "skip patterns" are included for selected OASIS items. These patterns allow the care provider to move quickly through the sections of the OASIS that do not apply to the particular patient. Other than items that are specifically noted to be "skipped," all OASIS items should be answered.

- *The follow-up and discharge assessments must be done without reference to the previous values for any health status item.* It is critical for data accuracy that the clinician does not merely duplicate items from the prior assessment rather than perform a new comprehensive assessment. Such "carry forward" of data results in error-ridden outcome reports, which are not usable by agencies for performance improvement.

- *Minimize the use of "Not Applicable" and "Unknown" answer options.* For some OASIS items, response options for "Not Applicable" or "Unknown" are available. We encourage clinicians to limit their use of these categories to situations where no other response is possible or appropriate. OASIS items have been reviewed carefully to determine whether "Not Applicable" or "Unknown" responses for patient health status items are consistent with good clinical practice. In several instances, "Unknown" is an acceptable response at start of care, but is not included as a response for the follow-up or discharge versions of the item because the care provider is expected to be sufficiently aware of the patient's condition or circumstances to provide the information. In almost all cases it is possible to collect the needed information without undue intrusiveness or burden for the patient. If a patient declines to provide information, that should be respected, while at the same time recognizing the clinician’s responsibility to complete the assessment using whatever information is available.

Because the OASIS items have been worded carefully to include most (item) instructions in the item itself, few specific instructions are required. However, some clinicians are more comfortable if they actually have a list of general

instructions for reference. Such a list is found in Attachment A to this chapter. This instruction page can be duplicated and used for agency training.

C. UNDERSTANDING THE MEANING OF EACH OASIS ITEM

The OASIS has undergone several years of development and refinement, as well as use by many home care agencies in various research and demonstration projects. During this process, the most common questions and misunderstandings about the items have been identified. The item-by-item review of the data set is found in Attachment B to this chapter. Each OASIS item is documented, the item definition is provided, the time points for data collection identified, response-specific issues or questions are addressed, and assessment strategies for obtaining the data are suggested. Agencies are encouraged to use this section in training staff and as the first reference source for answering questions.

D. COLLECTING OASIS DATA IN THE CONTEXT OF THE COMPREHENSIVE ASSESSMENT

Agency supervisory and administrative personnel occasionally question how the OASIS items are to be administered. Should the clinician use the OASIS as a structured interview tool by reading all of the items to the patient or family? Unequivocally, this is **not** an appropriate way to complete a patient assessment including OASIS. Instead, the clinician should perform the comprehensive assessment, gathering both interview and observation (or measurement) data as indicated. A few OASIS items clearly require interview of the patient/client or family (e.g., M0380 - Type of Primary Caregiver Assistance), while others are best obtained through observation (e.g., M0464 - Status of Most Problematic [Observable] Pressure Ulcer). Attachment B to this chapter provides specific assessment strategies for each item, to assist clinicians to collect the required information effectively and without unnecessary intrusiveness or burden for the patient. Experience with OASIS items indicates that the requisite information is easily obtained within the context of a routine complete assessment.

Table 8.1 presents the primary components of a home care patient assessment. Clinicians assess and collect information on these components in their own unique sequence, as dictated by circumstances, patient needs, and anticipated care requirements. The table depicts how various OASIS items relate to each of these assessment components, thereby showing where and how the OASIS items are best integrated into the patient assessment activity.

TABLE 8.1: Mapping of OASIS Items into Major Components of An Illustrative Patient Assessment at Start of Care.

Assessment Component and Elements Within Each Component	Related Patient Tracking Sheet/OASIS Item(s)
PREVISIT	
Telephone call prior to visit	
• Telephone availability	M0770
• Setting appointment time	M0770, M0400, M0410, M0560
VISIT	
Basic demographic information	
• Name, address, age, gender, pay source, etc.	M0010-M0150
Entrance to home	
• Patient's ambulatory status	M0700
• Patient remembered telephone call & appointment	M0560, M0570
Interior of home (as move from one room to another)	M0750
• Odors (urine, feces)	also M0520-M0540
• Kitchen (where you might wash your hands)	
- medications present in bottles or scattered	also M0780-M0800
• Bathroom (where you might wash your hands or what you ask to see to set up aide care plan)	M0670, M0680
- bathtub or shower	
- assistive equipment (grab bars, shower chair)	
- toilet	
- soiled clothes with urine or fecal odor	also M0520-M0540
- medications present in bottles or scattered	also M0780-M0800
History of present condition and symptoms	
• Hospitalization and reasons	M0175-M0190
• Onset of current illness	M0200-M0220
• Other comorbidities (severity and management)	M0250, M0500, M0510
• Presence of high risk factors	M0290
• Life expectancy	M0280
Family/caregiver assistance	
• Living situation	M0300, M0340
• Availability of family/caregiver assistance	M0350, M0360
• Other assistance needed and received	M0360-M0380, M0820
Medication inventory	
• Walk to where meds are kept	M0690-M0700
• Assess knowledge of medication schedule, dosage, etc.	M0410, M0560
• Assess ability to administer prescribed medications	M0780-M0800

TABLE 8.1: Mapping of OASIS Items into Major Components of An Illustrative Patient Assessment at Start of Care. (Cont'd)

Assessment Component and Elements Within Each Component	Related Patient Tracking Sheet/OASIS Item(s)
VISIT (continued)	
Physical assessment	
• Vital signs	
- orthostatic BP	M0690
- comprehension of instructions	M0400, M0560-M0570
• Weight	
- comprehension of instructions	M0400, M0560-M0570
- ability to stand, step on scale	M0690-M0700
• Head	
- vision	M0390
- hearing	M0400
- speech	M0410
• Skin condition	M0440-M0488
• Musculoskeletal and neurological	M0640-M0660, M0780-M0820
- joint function, grasp, pain, etc.	
- neurologic	also M0410-M0430, M0560
• Cardiorespiratory	
- dyspnea	M0490
- lung sounds; check ability to dress upper body	M0650
- circulation in lower extremities; check ability to dress lower body	M0660
• GI/GU	
- urinary status	M0510-M0530
- bowel status	M0540-M0550
• Nutritional status	M0710-M0720, M0760
Emotional/behavioral status assessment	M0560-M0590, M0610, M0620
ADLs/IADLs	
• Review any information not gathered already in sufficient detail	M0670-M0680, M0730-M0760
POSTVISIT	
Data review (in preparation for care planning)	
• Primary diagnosis and comorbidities	M0230, M0240, M0245
• Severity index	M0240
• Prognosis and rehab prognosis	M0260, M0270
• Need for psychiatric nursing services	M0630
• Need for physical, occupational, or speech therapy	M0825

The "discipline-neutrality" of the OASIS refers to the fact that the items were designed so nurses and therapists can use and administer the OASIS equally effectively. This property of discipline-neutrality has been built into the OASIS to ensure its utility for all planned applications. Staff training and open discussion of the items between and among staff from all disciplines are encouraged. This facilitates uniformity in cross-discipline data collection and reporting.

Some case examples of OASIS items are presented in Attachment C to this chapter. These scenarios provide an opportunity to practice answering OASIS items in response to patient situations. Agencies can also utilize their own patient situations as additional scenarios for the same purpose.

E. SOME UNUSUAL SITUATIONS: HOW TO USE OASIS

A variety of situations that produce questions about patient assessment and OASIS data collection can arise during the home care episode. Following are the situations which most often generate questions and the appropriate agency actions.

Situation	Appropriate Agency Action
Patient's primary pay source for skilled home care changes during the episode of care—from Medicare to an alternate pay source.	1. If the original start of care date is maintained, continue assessments and OASIS data collection/reporting according to that date. Report any new pay source (or delete any that no longer pertain) in an update to M0150 – Current Pay Sources for Home Care or the Patient Tracking Sheet. 2. If the start of care (SOC) date changes to coincide with the pay source change, the patient must be discharged (discharge date to coincide with last visit of "old" pay source). A new comprehensive assessment must occur with the new SOC date.
Patient's primary pay source for home care changes during the episode of care—from other-than-Medicare to Medicare.	This situation parallels response 2 (above). Follow the actions described there (i.e., discharge patient on last visit of "old" pay source, conduct new comprehensive assessment at new SOC date). A SOC comprehensive assessment and OASIS data collection is required when Medicare becomes the payer source.

Situation	Appropriate Agency Action
A patient is seen at very infrequent intervals (e.g., every 30 days, every 60 days, every 90 days, etc.). What should be done about the every 60 day comprehensive assessment?	An assessment will need to be performed during the five-day period immediately preceding the end of each certification period. Visits scheduled on a monthly or every two-month basis usually can be scheduled into this period. A patient needing a skilled visit only every 90 days will require other arrangements. Perhaps an aide supervisory visit can be done during the five-day period. (The required assessment must occur in the presence of the patient, not be conducted over the telephone.)
My agency has a nurse conduct a comprehensive assessment before the therapist begins a therapy-only case. Thus, the nurse's assessment is done before the start of care (SOC) date. Can we continue this practice?	The data entry software (HAVEN) and the State system software will generate an error message for a comprehensive assessment done before the SOC date. The SOC comprehensive assessment therefore may be considered to be missing for the episode. Your agency can continue to have a nurse conduct a comprehensive assessment early in the episode, but it will need to be done either the same date as the therapist's SOC date or afterward. Alternatively, your agency could modify its policy and allow the therapist to conduct the SOC comprehensive assessment for the therapy-only cases.
What should I do if I learn later that the patient was hospitalized for more than 24 hours? Sometimes I do not learn of this hospitalization until my next visit.	Complete the Transfer to Inpatient Facility form (with or without agency discharge according to your agency's policy). (For M0090 – Date Assessment Completed, record the date you learned of the hospitalization. For M0906 – Discharge/Transfer/Death Date, record the date the patient was transferred to the inpatient facility.) The date you are now seeing the patient becomes the new start (or resumption) of care date, depending on your agency policy.

FREQUENTLY ASKED QUESTIONS

1. How can I make sure that my staff is answering the OASIS items correctly? I'm particularly concerned about one clinician substituting for another when there are vacations, sick days, or other absences.

There are actually two parts to the response to this question (and your concern). First, your agency has considerable potential to impact the accuracy of the OASIS data -- starting with your early training and orientation to OASIS items. Using the training materials provided in this manual (and other updates issued through the OASIS web site) and adhering to the item definitions included in Attachment B to this chapter are a good beginning. Encourage your clinicians to refer to the item-by-item information provided in Attachment B when they have questions.

This early training and orientation continues as you respond to frequently asked questions in your agency. Include the appropriate responses to these questions in newsletters or post them in highly-viewed places in your agency. Staff or team meetings can have a few minutes devoted to OASIS items during the early weeks and months of using the data set. Approaches to data accuracy and data quality monitoring that are included in later sections of this manual also help you to pinpoint areas of difficulty in the way your staff utilizes and responds to OASIS items. Your ongoing attention to data accuracy and integrity will serve as a good example to your clinical staff of the importance of high quality data.

The second part of the response concerns the OASIS items themselves. Recall that the items have been tested for interrater reliability at several points during their development, testing, and ultimate use in demonstration projects. Such reliability testing will continue to occur as the items are modified for various reasons over time.

FREQUENTLY ASKED QUESTIONS

2. Do different disciplines assess the patient in the same way? I wonder whether the nurse and therapist, when encountering the same situation, actually "see" the same thing.

The precise assessment methods used by different clinicians can vary, not only between disciplines but also between different clinicians in the same discipline. This is the reason why OASIS items that are scales contain more detailed descriptive responses than simply numerical levels. Regardless of the assessment method, the description assists the clinician to determine the appropriate response level for the patient.

As noted in the response to Question 1 (above), the orientation, training, and ongoing monitoring of data accuracy within the agency also can focus on drawing similar conclusions from specific situations. It is particularly appropriate to utilize "real" agency patients in discussions of both assessment practices and appropriate responses to OASIS items. Many agencies have reported that such discussions actually serve to increase the overall clinical competencies of their staff in performing patient assessments.

3. Will there be any further revisions to the OASIS-B1 data set currently posted on the OASIS web site?

The OASIS-B1 (12/2002) data set posted on the Web site is the most current version. It was recently updated as part of the Department of Health and Human Services (HHS) department-wide initiative to reduce regulatory burdens in health care and to address the concerns of health care providers, state and local governments, and individual Americans who are affected by HHS rules. Please continue to check the OASIS Web site for updates.

ATTACHMENT A TO CHAPTER 8

GENERAL OASIS INSTRUCTIONS

1. OASIS items can be completed by any clinician who performs the comprehensive assessment. The Conditions of Participation and agency policy should determine who is responsible for completing the comprehensive assessment (and OASIS items) if individuals from more than one discipline (e.g., PT and OT) are seeing the patient concurrently.

2. All items refer to the patient's usual status or condition at the time period or visit under consideration -- unless otherwise indicated. Though patient status can vary from day to day and during a given day, the response should be selected that describes the patient's status most of the time during the specific day under consideration.

3. Some items inquire about events occurring within the past 14 days or at a specified point (e.g., discharge from an inpatient facility, ADL status at 14 days prior to start of care, etc.). In these situations, the specific time interval included in the item should be followed exactly.

4. OASIS items that are scales (e.g., shortness of breath, transferring, etc.) are arranged in order from least impaired to most impaired. For example, higher values (further down the list of options) on the transferring scale refer to greater dependence in transferring. This is true whether the scale describes a functional, physiologic, or emotional health status attribute.

5. Collection of data through direct observation is preferred to that obtained through interview, but some items (e.g., frequency of primary caregiver assistance) are most often obtained through interview. When interview data are collected, the patient should be the primary source (or a caregiver residing in the home). An out-of-home caregiver can be an alternate source of information if neither of the others are available, but should be considered only in unusual circumstances. In many instances, a combined observation-interview approach is necessary. For example, by speaking with the patient or informal caregiver while conducting the assessment, the provider can determine whether the observed ability to ambulate is typical or atypical at that time. Such combined approaches of observation and interview occur frequently during most well-conducted assessments, but warrant mention here in order to clarify the meaning of OASIS items.

6. The OASIS items may be completed in any order. Because the data collection is integrated into the clinician's usual assessment process, the clinician actually performing the patient assessment is responsible for determining the precise order in which the items are completed.

7. Unless a skip pattern is indicated (and followed), every OASIS item for the specific time point should be completed.

8. Unless the item is noted as "Mark all that apply," only one answer should be marked.

9. Minimize the selection of "Not Applicable" and "Unknown" answer options.

10. Each agency is responsible for monitoring the accuracy of the assessment data and the adequacy of the assessment process.

ATTACHMENT B TO CHAPTER 8

OASIS ITEM-BY-ITEM TIPS

OASIS ITEM:
(M0010) Agency Medicare Provider Number: — — — — — —
DEFINITION:
Agency's Medicare provider number
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet)
RESPONSE—SPECIFIC INSTRUCTIONS:
Enter the agency's Medicare provider number, if applicable. If agency is not a Medicare provider, leave blank.
ASSESSMENT STRATEGIES:
Agency administrator and billing staff can provide this information. This number may be preprinted on clinical documentation (recommended).

OASIS ITEM:

(M0012) Agency Medicaid Provider Number: __ __ __ __ __ __ __ __ __ __

DEFINITION:

Agency's Medicaid provider number

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet)

RESPONSE—SPECIFIC INSTRUCTIONS:

- Enter the agency's Medicaid provider number, if applicable. If agency is not a Medicaid provider, leave blank. If there are fewer digits than spaces provided, leave spaces at the end blank.

ASSESSMENT STRATEGIES:

Agency administrator and billing staff can provide this information. This number may be preprinted on your clinical documentation (recommended).

OASIS ITEM:
(M0014) Branch State: __ __
DEFINITION:
The State where the agency branch office is located.
TIME POINTS ITEM(S) COMPLETED:
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
RESPONSE—SPECIFIC INSTRUCTIONS:
Enter the two-letter postal service abbreviation of the State in which the branch office is located. Leave blank if your agency has no branches or all branches are located in the same State.
ASSESSMENT STRATEGIES:
Agency or branch administrator can provide this information.

OASIS ITEM:

(M0016) Branch ID: __ __ __ __ __ __ __ __ __ __

DEFINITION:

Branch identification code, as defined by the agency (currently) or assigned by the Centers for Medicare & Medicaid Services (CMS). Federal branch ID numbers are expected to be assigned by CMS by 12/31/2003. Currently, any combination of numeric and/or alphabetic characters may be used for this code. When assigned by CMS, the identifier will consist of 10 digits -- the State code as the first two digits, followed by Q (upper case), followed by the last four digits of the current Medicare provider number, ending with the three-digit CMS-assigned branch number.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet) and updated if change occurs during the episode.

RESPONSE—SPECIFIC INSTRUCTIONS:

- Enter the Federal branch identification number specified for this branch as assigned by CMS. Until the Federal branch identification number is assigned, agencies may choose to enter a branch identification code as defined by the agency. If the agency code has fewer digits than spaces provided, leave spaces at the end blank.
- If the agency has no branches, enter "N" (left-justified) after 12/31/2003.
- If the assessment was performed by the home office of an agency which has branches, enter "P" (left-justified) after 12/31/2003.

ASSESSMENT STRATEGIES:

Agency or branch administrator can provide this information.

OASIS ITEM:

(M0020) Patient ID Number: _

DEFINITION:

Agency-specific patient identifier. This is the identification code the agency assigns to the patient and uses for record keeping purposes for this episode of care.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet)

RESPONSE—SPECIFIC INSTRUCTIONS:

- The patient ID number may stay the same from one admission to the next or may change with each subsequent admission, depending on agency policy. However, it should remain constant throughout a single episode of care (e.g., from admission to discharge).
- If there are fewer digits than spaces provided, leave spaces at the end blank.

ASSESSMENT STRATEGIES:

Agency medical records department is the usual source of this number.

OASIS ITEM:

(M0030) Start of Care Date: __ __ /__ __ /__ __ __ __
month day year

DEFINITION:

The date that care begins. When the first reimbursable service is delivered, this is the start of care.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet)

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.
- In multidiscipline cases, agency policy will establish which discipline's visit is considered the start of care.
- Accuracy of this date is essential; many other aspects of data collection are based on this date.

ASSESSMENT STRATEGIES:

If questions exist as to the start of care date, clarify the exact date with agency administrative personnel.

OASIS ITEM:

(M0032) Resumption of Care Date: __ __ /__ __ /__ __ __ __ ☐ **NA – Not Applicable**
month day year

DEFINITION:

The date of the first visit following an inpatient stay by a patient currently receiving service from the home health agency.

TIME POINTS ITEM(S) COMPLETED:

SOC (Patient Tracking Sheet) and updated when ROC occurs.

The resumption of care date must be updated on the Patient Tracking Sheet whenever a patient returns to service following an inpatient facility stay.

RESPONSE—SPECIFIC INSTRUCTIONS:

- At start of care, mark "NA."
- The most recent resumption of care should be entered.
- Agencies who always discharge patients when they are admitted to an inpatient facility will not have a resumption of care date.
- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.

ASSESSMENT STRATEGIES:

If question exists as to the resumption of care date, clarify with the agency administrative staff.